**New Jersey Department of Health and Senior Services**
**Office of Managed Care**
**PO Box 360**
**Trenton, NJ 08625-0360**
Toll-Free Number: 1-888-393-1062

| FOR STATE USE ONLY |
|---|
| Date Rec'd |
| File No |
| Category |
| Invest. |

# COMPLAINT

*Instructions: Please print or type this entire form, and mail to the address listed above. The form must be signed and dated.*

| | |
|---|---|
| Name of Complainant | Type ☐ Consumer ☐ Provider |
| Name of Carrier | Member ID Number |
| Subscriber Name | Subscriber ID Number |
| Street Address of Complainant | Telephone Number (Home) |
| City County State Zip Code | Telephone Number (Business) |
| On Behalf Of (if same as above, write "SAME") | |
| Coverage is Through: ☐ Work ☐ NJ Family Care ☐ Medicare ☐ Federal ☐ Individual ☐ Medicaid ☐ NJ State Health Benefits Government | |
| Details of Complaint (Include copies of documents and correspondence that you believe will assist us in our inquiry. Do not use the back of this form; however, you may attach additional pages if necessary.) | |
| Have you utilized the Carrier's Internal Complaint/Grievance Appeal Process? ☐ Yes ☐ No | |

*In order to assist the Department in our inquiry of your complaint, we request that you sign and date the following authorization for the release of information:*

I understand that a copy of this form and any enclosures may be sent to the carrier named in the complaint and I authorize the release to the New Jersey Department of Health and Senior Services any medical and/or administrative records pertinent to this complaint.

| | |
|---|---|
| Signature of Complainant | Date |

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